

RESEARCH UPDATE

ON ADOLESCENT SUBSTANCE ABUSE AND CO-OCCURRING ISSUES:
A RESOURCE FOR TREATMENT PROFESSIONALS AND EDUCATIONAL CONSULTANTS
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FOCUS OF THIS UPDATE:

TRAUMA AND SUBSTANCE ABUSE IN ADOLESCENTS

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~“It’s time to stop ignoring the elephant in our counseling rooms.” - Michael Dennis, Ph.D. ~

Substance use disorders typically occur in conjunction with a wide range of other mental and behavioral problems, but of particular concern is the high rate of trauma and victimization among adolescent substance abusers. These high rates of co-occurring disorders in general, and trauma in particular, challenge clinicians and treatment facilities to seek more specialized and effective approaches.

DEFINING TRAUMA

Traumas are any of a number of events that can potentially cause extreme emotional distress including direct threats to bodily integrity such as physical and sexual assaults, as well as witnessing violence or death, abandonment, betrayal, emotional abuse, and child neglect (Hawke, Albert, Ford, in press, 2008). While the more traditional conceptualization of trauma includes overtly threatening events (witnessing or experiencing sexual or physical abuse, natural disasters, terrorism, etc.) psychological trauma can also occur with less obvious stressors such as the death of a loved one, parental divorce, mild bullying at school, etc.. Identifying problems associated with trauma is often difficult because many adolescents who are exposed to traumatic events do not develop full PTSD according to criteria in the DSM-IV. And while many adolescent victims do not meet PTSD full criteria they often struggle with problematic symptoms and co-occurring issues, including substance abuse as well as other problems, which require specialized treatment.

WHY TRAUMA AND SUBSTANCE ABUSE CO-OCCUR

Research has consistently documented a strong link between trauma exposure and substance abuse among adolescents (Chan et al., in press; Funk et. al, 2003; Shane et al.; and Titus et al., 2003). Several pathways have been identified in this connection between trauma and substance abuse in adolescence (Giaconia, Reinherz, Paradis, & Stashwick, 2003) including:

- Self-Medication Hypothesis -- Adolescents experiencing traumatic stress may drink or take drugs in an attempt to manage or self-medicate their feelings of anxiety, physiological arousal, depression, hopelessness, loneliness, or grief.
- High Risk Hypothesis -- Teens who abuse substances are more likely to experience traumatic events, presumably because they are more likely to engage in risky activities.
- Susceptibility Hypothesis -- Youth who are already abusing substances may be less able to cope with a traumatic event as a result of the functional impairments associated with problematic use.
- Other research with adults suggests that substance use craving increases among individuals with co-occurring trauma and substance abuse when they are exposed to cues related to the traumatic event (Coffey, et al., 2002; Saladin, et al., 2003).

THE PREVALENCE OF TRAUMA AMONG SUBSTANCE USING TEENS

Research suggests that some degree of trauma history is often the rule rather than the exception among substance abusing teens. In a recent study, Shane and colleagues (2006) found victimization rates from 85% to 91% of residential and from 59% to 65% of outpatient adolescent substance abuse clients. However, the type of victimization varied with females more likely to report being victims of sexual and emotional abuse and males more likely to report being attacked with a weapon.

Table 1. Comparison of males and females within outpatient and residential substance abuse care

Victimization (% reporting lifetime history)	Outpatient		Residential	
	Females (n=104)	Males (n=496)	Females (n=125)	Males (n=250)
Ever Been Victimized	65.4	59.1	91.2	85.2
Ever Attacked with a Weapon	16.4	45.2	40.8	64.4
Ever Hurt by Striking/Beating	26.0	24.8	52.0	54.0
Ever Forced to Have Sex Against Will	21.2	1.61	42.4	6.4
Ever Abused Emotionally	44.2	15.5	84.8	43.2

Findings also suggests that a history of traumatic distress is associated with more intense substance abuse problems. In another recent study, Chan and colleagues (in press) found that an adolescent's likelihood of being substance dependent increased among those who had histories of traumatic distress (see Table 2).

Table 2. Association of past-year dependent status by age

Past-year substance use problems	Age < 15 (n=916)	Age 15-17 (n=4014)	Age 18-25 (n=676)
Traumatic Distress			
Dependence	50.6	51.5	63.7
No dependence	25.2	23.9	28.9

This same study reported that treatment outcomes were worse for substance abusing adolescents with more significant trauma histories. Chan and colleagues (in press) found that treatment participants who did not reduce their use at follow-up were more likely than those who did reduce use to have reported (a) that victimization occurred before age 12 (41% vs. 17%), (b) their victimization experiences involved more than one person (53% vs. 33%), (c) they were currently worried that someone would beat or hurt them (24% vs. 6%), and (d) that they were not believed by the people they told (35% vs. 22%).

"Emotional distress is related to relapse. And among adolescents there is such a high overlap between emotional distress and substance abuse. That's kind of a recipe for disaster... If you look at substance use by level of trauma the picture that is coming out of research is that kids with high or low trauma use similar levels of marijuana. But among the kids who have more severe histories of trauma and abuse there is more use of alcohol and harder drugs."

- Janet Titus, Ph.D.

IMPLICATIONS FOR TREATMENT FACILITIES

Given the high prevalence of trauma among substance abusing adolescents, research and clinical experts have given repeated calls for treatment professionals to become better versed in the treatment of trauma victims. A recent article by Dr. Michael Dennis (2004) provides several specific recommendations for treatment facilities, including:

- **Placement in the appropriate level/intensity of care** – Research by Titus and colleagues (2003) found that adolescents in a “high” victimization range responded to residential but not outpatient treatment.
- **Systematically screen for victimization and the degree of trauma at intake.** Including simple but explicit questions about victimization at intake and/or more detailed screening instruments to gauge the severity of trauma (e.g. the GAIN’S General Victimization Scale – see www.chestnut.org/li/gain) can actually help to “normalize” the process for both clients and staff. (See section below for more about screening)
- **Train staff on how to respond to victimization**, in terms of not only mandated reporting but also the timing and facilitation of assessment, diagnosis, and treatment. (See section below for more on treatment)
- **Given the strong association between trauma and substance use, inclusion of trauma as part of treatment processes could be crucial in strengthening engagement, retention and treatment effectiveness for youth with histories of abuse.** Discharge planning to address the potential for abuse in recovery environments may also make a strong contribution to relapse prevention.
- **Recognize that addressing victimization is complex.** Family members can run the gambit from being very supportive, hurt/angry at the perpetrator, or they may even include one of the abusers. Even when there has been victimization, the adolescent often will still have a strong bond to the aggressor.
- **Recognize that there are also incidents where a person is both a victim and an abuser.** Moreover, this may be playing out “during” the treatment period. Such adolescents may not be appropriate for group sessions, either emotionally or because they would put others in the group at risk.
- **Address other staff concerns about screening for victimization.** Many staff are personally uncomfortable talking about victimization and project their feelings onto the client. This can be because they have no frame of reference (which can lead to disbelief or blaming the victim) or because they have personal experiences with victimization (often for which they received little or no help). Ideally, part of staff training will include time for them as individuals to explore and address these issues from their personal perspective. This will help them keep the assessment focused on the client before them instead of on their own personal issues.

SCREENING AND ASSESSMENT TOOLS

One common hurdle is that many of the signs of both trauma and substance abuse are similar to problem behaviors that are part of the natural developmental course of adolescents. Or in the words of some experts, the signs are often “not visible.” However, what is evident from research is that there is a high incidence of victimization among adolescents entering treatment, and that a screener for victimization (preferably with standardized items) should be included in the assessment process. When the screener indicates past or current victimization, intake professionals should use interviewing techniques to understand more about the abuse. Dimensions that should be explored further include the type of abuse (emotional, physical, sexual), severity of abuse, the frequency of abuse, location of abuse (home, school, neighborhood), who is/are the perpetrator(s) (family, peer, stranger), and the time frame in which the abuse occurred (Shane et al., 2006). Providing screenings for all clients can also help to “normalize” the process for both clients and staff.

For a useful review of standardized measures see pages 60-61 of the Toolkit created by the National Child Traumatic Stress Network at http://www.nctsnet.org/nctsn_assets/pdfs/4_Treatment_4-18-07.pdf

RECOMMENDED TREATMENT APPROACHES AND MODELS

For detailed information related to effective, research-based treatment of trauma and substance abuse in adolescents please see the following links:

- http://www.nctsnet.org/nccts/nav.do?pid=ctr_top_adol

This is a document entitled “Understanding Links between Adolescent Trauma and Substance Abuse: A Toolkit for Providers.” This toolkit contains materials for health care providers, parents, and teenagers. It is designed to raise awareness about the needs of youth with traumatic stress and substance abuse problems and to promote evidence-based practices in clinical settings. The toolkit was created by the Adolescent Trauma and Substance Abuse Committee of the National Child Traumatic Stress Network (NCTSN) and was published in April 2007. NCTSN is funded by the Substance Abuse Mental Health Services Administration (SAMHSA) and has done significant groundwork identifying programs and examining the evidence supporting their use. A brief table of this work is provided at http://www.nctsnet.org/nctsn_assets/pdfs/promising_practices/NCTSN_E-STable_21705.pdf.

- http://www.rand.org/pubs/technical_reports/TR413/

This link is for a document entitled “How Schools Can Help Students Recover from Traumatic Experiences: A Tool Kit for Supporting Long-Term Recovery (2006), by Jaycox, Morse, Tanielian, and Stein. This is an excellent toolkit to help take administrators/clinicians through the process of choosing an approach that suits their needs. It provides a compendium of programs for trauma recovery, classified by type of trauma (i.e. natural disasters, exposure to violence, etc.). the toolkit also facilitates comparison of programs across several dimensions, such as program goals, target population, mechanics of delivery, implementation requirements, and evidence of effectiveness.

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